ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year: _____-_____

STUDENT INFORMATION

Student's Name: _____ **School:** _____

Date of Birth: ____/____/_____ Age: _____ Grade: _____ Teacher: _____

☐ **No known drug allergies---if drug allergies list:** _____ Weight: _____pounds

OVER THE COUNTER PRESCRIBER AUTHORIZATION (FORM B)

Medication Name: _____ **Dosage:** _____ **Route:** _____

Frequency/Time(s) to be given: _____ **Start Date:** ___/___/___ **Stop Date:** ___/___/___

PHYSICIAN ORDER REQUIRED by LEA : YES ____ **NO**____

Reason for taking medication: _____

Potential side effects/contraindications/adverse reactions: _____

Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes ☐ No ☐

Is self- medication permitted and recommended? Yes ☐ No ☐

If "yes" I hereby affirm this student has been instructed
On proper self-administration of the prescribe medication.

Do you recommend this medication be kept "on person" by student? Yes ☐ No ☐

Printed Name of Licensed Healthcare Provider: _____ **Phone:** ( )_____-_____ **Fax:** ____-_____

Signature of Licensed Healthcare Provider: _____ **Date:** _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____ **Date:** ___/___/___ **Phone:** ( )_____-_____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ **Date:** ____/____/_____ **Phone:** ( )_____-_____